10288

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: near Laurel
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Laurel, Maryland

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: near Laurel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Laurel, Maryland
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby girl (Adams) "A" (first of twins)

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Negro

6. (a) Single, married, widowed, or divorced: -

6 (b) Name of husband or wife: none

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 31, 1940

8. AGE: Years | Months | Days | If less than one day: 3 hrs. 55 min.

9. Birthplace: near Laurel, Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: George Gross
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Catherine Adams
15. Birthplace: Washington, D. C.

16. Informant: Records of Inst.
Address: Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 1, 1940 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: District Training School

18. Funeral director: Dr. James Lewald

Address: Laurel, Maryland

19. Nov 1 1940 (Date rec'd by registrar) Clara M Hasluft Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1940, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1940, to October 31 1940, and that I last saw her alive on Oct. 31 1940.

Immediate cause of death: prematurity of birth

Due to: asphyxia due to depression of central respiratory centers

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: - Date of

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -

Means of Injury: - Injured at work? -

23. SIGNATURE: James Hurley M.D. M. D. or other

Address: Laurel, Md. Date signed: 10/31/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8)

10289

Reg. Dist. No. 4/1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County a.a.
City or town Round Bay
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution:
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a.a.
City or town Round Bay Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still Born Baierlein (Baierlein)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Female~~ M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 1940

8. AGE: Years | Months | Days | If less than one day ___hrs. ___min.

9. Birthplace Round Bay (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Baierlein
13. Birthplace a.a. Co Md

MOTHER 14. Maiden name Florence Gardner
15. Birthplace Maryland

16. Informant John Baierlein
Address Severna Park, Md. Post office

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22/40 (month) (day) (year)
Cemetery or crematory Cedar Neff
Location Annapolis Md

18. Funeral director B. L. Hopkins
Address Annapolis Md

19. 10-25 (Date rec'd by registrar) 1940 J. M. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1940, at ~~P.M.~~ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 1940, to Oct 21 1940, and that I last saw ~~him~~ her on Oct. 21 1940.

Immediate cause of death	DURATION
Stillborn	
Due to Intrauterine Atelectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice J. Klawans M.D.
M. D. or other
Address 31 Smithgate Av Date signed 10/21/40

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10290

93-d

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County a a

City or town Homewood Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Near annapolis.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 39 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a. a.

City or town Homewood. Near annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No 20 woodland Dr
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Richard J. Bassford

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Eliza J Bassford

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1881

8. AGE:

Years	Months	Days	If less than one day
58	10	6	hrs. min.

9. Birthplace maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Clerk. Naval academy

FATHER
12. Name James H. Bassford
13. Birthplace Maryland

MOTHER
14. Maiden name Mary E Wells
15. Birthplace Maryland

16. Informant Eliza J. Bassford
Address 20 woodland dr Homewood.

17. Burial Date thereof Oct 24-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis. Maryland

18. Funeral director B. L. Hopkins

Address Annapolis. Maryland

19. Oct 24 1940 J. M. Nash
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940, to Oct. 22 1940,
and that I last saw h alive on Oct. 22 1940.

	DURATION
Immediate cause of death Myocarditis & Myocardial Degeneration	1 year.
Due to Hypertension	August
Due to Chronic Nephritis	August
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boyd
M. D. or other

Address Annapolis Md Date signed 10-23-40

RECEIVED
NOV 5 1940
[illegible] V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124b)

CERTIFICATE OF DEATH

10291

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days): 13 Days

Stay in this community (yrs., or mos., or days): 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 169 West St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: ANNA R. BEALL

3. (b) Social Security Number: 214-05-1455

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry Beall

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 11, 1879

8. AGE: Years 60 Months 11 Days 28 If less than one day ____ hrs. ____ min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Tailoress

11. Industry or business

FATHER
12. Name: William Curry
13. Birthplace: Ireland

MOTHER
14. Maiden name: Emily Garner
15. Birthplace: St. Mary's Co. Md.

16. Informant: Mrs. Charles H. Brooks
Address: Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 11, 1940 (month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor
Address: Annapolis, Md.

19. Oct. 9th, 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1940, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 1940 to October 8 1940, and that I last saw her alive on October 8, 1940.

	DURATION
Immediate cause of death: (1) acute dilatation of heart	Lunatic
Due to (1) Myocarditis (Chronic) (Unknown)	1 yr.
Due to (2) Chronic Interstitial Nephritis (Unknown)	1 yr.
Other conditions: Cirrhosis of liver	1 yr.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson M. D. or other
Address: Annapolis, Md. Date signed: 10/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10292

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 6 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Calvert St
(If rural, give LOCATION)
2.(a) If veteran, name war WW

3.(a) FULL NAME Stephen Beard

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	M

6.(b) Name of husband or wife Bertha C Beard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 18 1870

8. AGE: Years 70 | Months 0 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Portland Me (Town, county, and state)

10. Usual occupation Gardener

11. Industry or business

FATHER 12. Name Edward C Beard
13. Birthplace England Md

MOTHER 14. Maiden name Genevra Barker
15. Birthplace Anne Arundel Co Md

16. Informant Stephen Beard
Address 52 Calvert St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1940 (month) (day) (year)

Cemetery or crematory Woodlawn
Location Woodlawn Md

18. Funeral director Wallace Cook
Address 1217 St Paul St. Baltimore Md

19. 10-29 1940 (Data rec'd by registrar) J. H. Hungerford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1940, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to Oct 29 1940
and that I last saw h.. alive on Oct 28 1940

	DURATION
Immediate cause of death Carcinoma Stomach	6 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Hungerford M. D. (M. D. or other)
Address Annapolis Md Date signed 10-29-40

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

11065

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Owensville, West River P.O. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Owensville
(If outside city or town limits, write RURAL and give nearest town)
Street No. West River, P.O.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Pre-mature infant of Mary Bell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 19. 1940

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace Owensville, A.A. Co., Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name Thos. Clarence Bell
13. Birthplace

MOTHER
14. Maiden name Mary Moreland
15. Birthplace

16. Informant Mary Bell
Address Owensville Md

17. ..... Date thereof .....
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location

18. Funeral director
Address

19. ..... 19.....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1940, at 1.40 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 21 1940 to Oct. 21 1940
and that I last saw deceased alive on Oct. 21 1940

Immediate cause of death	DURATION
Pre-mature birth	
Due to 6½ months pregnancy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John M. Caffey Deputy medical examiner
M. D. or other
Address Annapolis Md Date signed Oct. 21 1940

(Burial permit to be issued by registrar No. 20 DATE 7/26/41)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 12 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10293

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 82 Market St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William Marcy Boucher

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Rosa Boucher
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1st 1856

8. AGE:

Years	Months	Days	If less than one day
84	8	10	hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Messenger to Maryland
11. Industry or business: Court of Appeals
FATHER 12. Name: Joseph L. Boucher
13. Birthplace: Annapolis Md.
MOTHER 14. Maiden name: Katherine Johnson
15. Birthplace: Annapolis Md.
16. Informant: John W. Boucher
Address: 82 Market St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14th 1940 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Annapolis Md.
18. Funeral director: John W. Taylor
Address: Annapolis Md.
19. 10-12th 1940 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11th 1940, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4th 1940, to Oct 11 1940
and that I last saw him alive on Oct 11 1940
Immediate cause of death:
C. Myocarditis — DURATION: several months
Due to: Asthma — sudden Jan 4th 1940
Due to: Arteriosclerosis Pertussis — yrs.
Other conditions: Hemiplegia right Side with Gangrene of right foot.
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Bowen M. D. or other
Address: Annapolis Md. Date signed: 10/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
N.Y.S.

State

HEALTH DEPARTMENT—~~CITY OF BALTIMORE~~

10294

CERTIFICATE OF DEATH (45-A)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Md St., Ward)

Registered No. 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Lawson A Brooks

If U. S. Veteran specify WAR

(a) Residence: No. Morris Hill ~~St.,~~ ~~Ward.~~

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. Color or Race Col

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Brooks

6. DATE OF BIRTH (month, day, year) Sept 23 1880

7. AGE Years 60 Months Days 11 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. "

10. Date deceased last worked at this occupation (month and year) 1939

11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Henry Brooks

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Rebecca Jennings

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Lillie Brooks (Address) Morris Hill

18. BURIAL, CREMATION, OR REMOVAL Place Mt Calvary Ct Date 10-8-40 19

19. UNDERTAKER Isaiah L. Brown & Son (Address) 108 W Montgomery St

20. FILED Oct 7 1940 Mrs De Alba Dep Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 4, 1940

22. I HEREBY CERTIFY, That I attended deceased from July 9, 1940 to Oct 4, 1940

I last saw him alive on Oct 3, 1940 Death is said to have occurred on the date stated above, at 4:15 P.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Broncho Pneumonia	Oct 1 1940
Other contributory causes of importance: Carcinoma of Lip	1939

Was an operation performed? no Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Microscopical-clinical Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) J. Ins Bowley, M. D.

(Address) 519 N Carrollton Av

VS 3

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family, cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.

9.—The industry or business in which the work was done.

10.—The month and year the deceased last worked at the occupation.

11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver*, etc.

In stating the industry or business avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10295

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 89 Northwest st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 89 Northwest st.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Still Birth Queen (Brown) **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 15 1940

8. AGE: Years	Months	Days	If less than one day
XX	X		hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Thomas Queen
13. Birthplace: Annapolis Md.
MOTHER 14. Maiden name: Jane Brown
15. Birthplace: Anne Arundel Co.
16. Informant: Thomas Queen
Address: 111 Clay st Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16 1940 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: On Washington rd. outside Annapolis Md.
18. Funeral director: Chas H. Stevenson Annapolis Md.
Address: 45 Northwest st. Annapolis Md.
19. 10/16 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 19 40 at 10:30A m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct October 15 19 40, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Stice Birth	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S Ambrose Garcia M. D. or other
Address: 35 Northwest St Date signed: 10-15-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

10296

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County A. A.

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A. A.

City or town Parole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bessie Brown

3. (b) Social Security Number

4. Sex: Fem

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mack Brown

6(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 30 | Months | Days | If less than one day ___ hrs. ___ min.

9. Birthplace Mckendree
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John Wiseman
13. Birthplace Mckendree

MOTHER
14. Maiden name Georgeanna Wittington
15. Birthplace Bristol

16. Informant John Wiseman
Address Parole

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 21 1940 (month) (day) (year)

Cemetery or crematory union Chaffee Cemetery

Location Bristol, Md

18. Funeral director J. B. Johnson
Address Annapolis

19. 10 21 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1940, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1940, to Oct 16 1940, and that I last saw her alive on Oct 16 1940.

Immediate cause of death: Acute dilatation of Heart — DURATION: Oct. 16th

Due to General Peritonitis — Aug.

Due to Ruptured appendix — Aug

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Genealogical Peritonitis
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE George C Bond M. D. or other

Address Annapolis Md Date signed 10-19-40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1940
BUREAU V. A.

10297

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (308)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 4 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. Russell Street (Street No. unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3. (a) FULL NAME

JAMES BROWN #7

3. (b) Social Security Number

----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1890 (?)

8. AGE: Years: 50? Months: Unknown Days: If less than one day ..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ----

FATHER
12. Name: Frank Brown
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Delia (Unknown)
15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-7-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

16. Funeral director: Supt.

Address

19. 10/7/40 (Date rec'd by registrar) 19 E. F. Joyce D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2nd 1940, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31st 1940, to Oct. 2nd 1940 and that I last saw him alive on Oct. 2nd 1940

Immediate cause of death	DURATION
Cerebral hemorrhage	20 hrs.
Due to	
Due to	

Other conditions: General paralysis of the insane
(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury: Injured at work: ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 10/2/40

VS A15 (T) (1) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

10298

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Rural, Severn River
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Near Annapolis Md
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 22 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Annapolis Neck Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Near Annapolis
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR World

3. (a) FULL NAME Lawrence C. Bullen
3. (b) Social Security Number None

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Hattie Bullen
6(c) If alive, give age 39 years
7. Birth date of deceased (mo., day, yr.) Aug 10 - 1898
8. AGE: Years 42 Months 1 Days 25 If less than one day ___ hrs. ___ min.
9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John F. Bullen
13. Birthplace Maryland
MOTHER 14. Maiden name Lottie Tanner
15. Birthplace Balto Md.
16. Informant Hattie Bullen
Address Annapolis R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13/40 (month) (day) (year)
Cemetery or crematory St Mary's
Location Annapolis Md
18. Funeral director B. L. Hopping
Address Annapolis Md.
19. Oct 13 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1940, at 8:00 A M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination ~~and that I last saw him alive on~~ Oct. 12. 1940.
Immediate cause of death Accidental Drowning
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Oct. 6, 1940
Where did injury occur? Annapolis (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Severn River
Means of injury Fell from bridge pier Injured at work? No
23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other
Address Annapolis, Md Date signed 10/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

10299

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(108)

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel CO

City or town: East Port

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: East Port

(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 2d st.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Emily Patricia Campell

3. (b) Social Security Number: —

4. Sex: Female

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: —

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19. 1940

8. AGE: Years | Months: 5 | Days: 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cristfield Md.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER

12. Name: William Campell

13. Birthplace: Md.

MOTHER

14. Maiden name: Della Williams

15. Birthplace: Cristfield, Md.

16. Informant: Della Williams

Address: 601 2d st. East Port Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31 1940 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: On Washington rd.

18. Funeral director: Charles H. Alexander Annapolis

Address: 43 and 45 Northwest Annapolis Md.

19. 10 31 1940 (Date rec'd by registrar) J. J. Mary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1940, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29 1940, to Oct. 29 1940 and that I last saw her alive on Oct. 29-1940 19.....

Immediate cause of death: Lobar Pneumonia

DURATION: 5 days.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Lenhardt M.D. M. D. or other

Address: East Port, Md. Date signed: 10-30-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

CERTIFICATE OF DEATH

10300

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days) Dead on arrival
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A.A. Co.
City or town Annapolis Neck Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. No number
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Baby Girl Brown (Miscarriage 3 months) Carey

3. (b) Social Security Number None

4. Sex F
5. Color or race Col.
6. (a) Single, married, widowed, or divorced Miscarriage
6 (b) Name of husband or wife None
6(c) If alive, give age No years
7. Birth date of deceased (mo., day, yr.) Oct. 4, 1940
8. AGE: Years Miscarriage Months Days If less than one day ____hrs. ____min.
9. Birthplace Annapolis Md - A.A. Co. (Town, county, and state)
10. Usual occupation Miscarriage
11. Industry or business Miscarriage
FATHER 12. Name Kensell Brown
13. Birthplace Annapolis Md
MOTHER 14. Maiden name Mary Louise Carey
15. Birthplace Annapolis Md
16. Informant Mary Louise Carey
Address Annapolis Md Same
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/40 (month) (day) (year)
Cemetery or crematory Father's burying ground
Location Annapolis Md
18. Funeral director Father - Kensell Brown
Address #1 Calvert St.
19. Oct 4 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1940, at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1940, to Oct. 4 1940, and that I last saw h alive on 1940.

Immediate cause of death Miscarriage
Due to 3 months
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations Miscarriage 3 mo.
Of autopsy No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gilbert L. Anderson M.D.
M. D. or other
Address Annapolis, Md Date signed Oct 4/40

RECEIVED
NOV 5 1940
HILO, H. T.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10301

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 528 N. Bruce St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: HARRY CHESLEY

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
68 M	black	married

6.(b) Name of husband or wife: XX Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years	Months	Days	If less than one day
68	Unknown		... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: ----

FATHER

12. Name: Joseph T. Chesley

13. Birthplace: Unknown

MOTHER

14. Maiden name: Ella Gilpin

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-7-40 (month) (day) (year)

Cemetery or crematory: Arbutus Mem. Park

Location: Balto. Co. Md.

18. Funeral director: Archibald A. Maddix

Address: 2101 Mc Culloh St.

19. Oct. 4 1940 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4th 1940 at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17th 1940, to Oct. 4th 1940

and that I last saw him alive on Oct. 4th 1940

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to	
Other conditions: Arteriosclerotic heart	disease

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury: Injured at work? ------

23. SIGNATURE: Hark V. Hamtramck M. D. or other

Address: Crownsville, Maryland Date signed: 10/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
U.S. AIR V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-1)

10302

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: U.S. Naval Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 month; 3 days
Stay in this community (yrs., or mos., or days): 86 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Ward No.: NONE
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 202 Prince George St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World War.

3. (a) FULL NAME: Dr. Gordon Handy Claude, Lt. (jg) (DC), USN Retired

3. (b) Social Security Number: NONE

4. Sex: M
5. Color or race: W-American
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Sophie Worthington Claude
6(c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.): October 22, 1854
8. AGE: Years: 85 Months: 11 Days: 16 If less than one day: ____ hrs. ____ min.
9. Birthplace: Annapolis (Anne Arundel Co.) Md.
(Town, county, and state)
10. Usual occupation: Dentistry.
11. Industry or business: Doctor, Dental Surgery
FATHER 12. Name: Abram Claude M.D.
FATHER 13. Birthplace: Annapolis, Md.
MOTHER 14. Maiden name: Rachel Tuck
MOTHER 15. Birthplace: Annapolis, Md.
16. Informant: Anne Claude Lovell
Address: 96 Cathedral St, Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8th 1940 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md
18. Funeral director: John M Taylor
Address: Annapolis Md.
19. Oct 7th 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6, 1940, at 1:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 1940, to Oct. 6, 1940, and that I last saw him alive on October 6, 1940

Immediate cause of death: Pneumonia, Broncho-
Not preceded by a cerebral hemorrhage
Due to: Hemiplegia, Arteriosclerotic — DURATION: 2 days
Not an aorta affair, but a slow passing. Syph.
Due to: Arteriosclerosis, general — DURATION: 6 mos.
He had one other hemiplegia attack.
Other conditions: Senility

(Include pregnancy within 3 months of death)

Major findings:
Of operations: NONE
Of autopsy: Not performed

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Malcolm W. Arnold, M.D.
Lieut. (MC) U.S. Navy
M. D. or other
Address: U.S. Naval Hospital, Annapolis, Md. Date signed: Oct. 6, 1940.

RECEIVED
NOV 5 1940
PALAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10303

1. PLACE OF DEATH (93-d)

County Anne Arundel Registration Dist. No.

Village or City Annapolis, Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Edward O. Diel

(a) Residence: No. Severna Park St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna S. Diel

6. DATE OF BIRTH (month, day, and year): May 6, 1877

7. AGE: Years 63 | Months 5 | Days 20 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Plumber.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Balto. Md.

FATHER

13. NAME: Edward F. Diel

14. BIRTHPLACE (city or town) (State or country): Balto.

MOTHER

15. MAIDEN NAME: Medora Traverse

16. BIRTHPLACE (city or town) (State or country): Balto.

17. INFORMANT (Address): Ms. Mike Diel, Severna Pk. Md.

18. BURIAL, CREMATION, OR REMOVAL

Place: Cedar Hill Date: 10-29, 1940

19. UNDERTAKER (Address): L. F. McCully, 130 E. Fort Ave.

20. FILED: 10-26, 1940 J. J. Murphy, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 26 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from January, 1936, to Oct 26, 1940

I last saw him alive on Oct 25, 1940; death is said to have occurred on the date stated above, at 6:30 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute Pulmonary Edema	10/26/40

Other Contributory Causes of importance:

Chr. Emphysema	yrs.
Chr. Myocarditis	1936
Cardiac Asthma	1938

Name of operation: none. Date of

What test confirmed diagnosis? Clinical Was there an autopsy? no.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no.

If so, specify

(Signed) Maurice F. Klawans M. D.

(Address) 31 Southgate av.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arterioselerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED NOV 5 1940 BUREAU V...

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82-a) Reg. Dist. No. 23

10304

CERTIFICATE OF DEATH

1. PLACE OF DEATH
(a) County Anne Arundel
(b) City or town Glenburnie, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 113 - 1st Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 20 yr.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glenburnie Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 - 1st Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Rachael Kate Hood Arnold Dixon

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Manoma E. Dixon

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Dec. 13. 1861

8. **AGE:** Years 78 | Months 9 | Days 28 | If less than one day ____hr. ____min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual occupation H.W. - Housework

11. Industry or business none

FATHER
12. Name Joshua Hood
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Brashear
15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs. Rosa Arnold
(b) Address Glenburnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14 1940 (month) (day) (year)
(c) Cemetery or crematory Prospect
Location Mt. Airy Md.

18 (a) Funeral director C. M. Wells
(b) Address Odenton (Waugh) Md

19 (a) Oct 12 40 (Date rec'd by registrar) (b) Md Dept of Health Registrar

MEDICAL CERTIFICATION

20. Date of death Oct. 11 1940, at 5:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1940, to Oct. 11 1940, and that I last saw him alive on Oct. 11 1940.

	Duration
Immediate cause of death: Cerebral Hemorrhage	Oct. 1-1939
Due to: Arterio sclerosis & Hypertension	1936
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Ball J. MD (M. D. or other)
Address Linthicum, Md. Date signed 10-11-40

VS. 415 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

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NOV 4 1940
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MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46-D)

Reg. Dist. No. 23

CERTIFICATE OF DEATH

10305

1. PLACE OF DEATH:

(a) County A. A.

(b) City or town No. Linthicum (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Hampton Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 6 mo.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1011 N. Monroe St (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Elizabeth Carl Fuhrman

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Paul E. Fuhrman

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1884

8. AGE: Years 56 Months 1 Days 26 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

FATHER 12. Name John Carl

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary Freeberger

15. Birthplace Baltimore

16 (a) Informant Paul E. Fuhrman

(b) Address 1011 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 1940 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Ritchie Highway AA

18 (a) Funeral director William Cook

(b) Address 1217 St Paul St

19 (a) Oct 31/40 (Date rec'd by registrar) (b) Matilda B. DeAlba Sep. Registrar

MEDICAL CERTIFICATION

20. Date of death Oct. 31 1940, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1939, to Oct. 31 1940, and that I last saw him alive on Oct. 31 1940.

Immediate cause of death Cancer of Liver — Duration 2 yrs.

Due to Metastasis from Ca. of rectum. Which was removed June 2. 1939. Has had colostomy since. — 2½-3 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. L. Ball Jr. M.D. (M. D. or other)

Address Linthicum Md. Date signed 10-31-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 4 1940
BUREAU V. S.

10306

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 16 yrs. 1 mo. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY SUSAN FEELAND

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widowed

6.(b) Name of husband or wife: Frank Freeland

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1865

8. AGE: Years: 75 Months: Unknown Days: If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/30-40 (month) (day) (year)

Cemetery or crematory: Crownsville

Location: "

18. Funeral director: Dept.

Address

19. 10/30 1940 (Date rec'd by registrar) E. T. Joyce D.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25, 1940, at 3.01 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5, 1924, to October 25, 1940 and that I last saw her alive on October 25, 1940

Immediate cause of death	DURATION
Bronchopneumonia	1 week
Due to	
Due to	
Other conditions: Pyelonephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 10/26/40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10307

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23

Village or City Patapsco No. 6 E. Furnace Rd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Edna V. Gies If U. S. Veteran, specify WAR ____

(a) Residence: No. 6 E. Furnace Rd St., Ward. ____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar R. Gies

6. DATE OF BIRTH (month, day, and year) May 7, 1908

7. AGE Years 32 Months 5 Days 23 If LESS then 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. X

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME George W. Johnson

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Ethel Lee

16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT Oscar R. Gies (Address) 6 E. Furnace Rd.

18. BURIAL, CREMATION, OR REMOVAL Cedar Hill Place Cedar Hill Date Nov 2, 1940

19. UNDERTAKER Harry H Witzke (Address) 4101 Edmondson Ave

20. FILED 31 Oct, 1940 Caldwell Woodruff Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 30 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1940 to Oct 30, 1940

I last saw her alive on Oct 29, 1940; death is said to have occurred on the date stated above, at 12:30 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Pneumonia	
Mandibulosis	3/6/40

Other Contributory Causes of importance:

Bronchopneumonia	1/3/40

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) J. F. Newton M. D.

(Address) 1 E. Randall St

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

10308

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County a a
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days) 3 days
Stay in this community (yrs., or mos., or days) 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a. a.
City or town Annapolis Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 54 West St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Jacob Greenberg

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6 (b) Name of husband or wife Katie Greenberg
6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) aug 10 - 1871

8. AGE:

Years	Months	Days	If less than one day
69	1	26	hrs. min.

9. Birthplace Russia (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Merchant

FATHER
12. Name Mordecai Greenberg
13. Birthplace Russia

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs Rose Greenberg
Address Annapolis. Maryland

17. Burial Date thereof Oct 7 - 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hebrew Friendship
Location Balto. Md.
18. Funeral director B L Hopping
Address Annapolis. Md.

19. 10-7th 1940 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1940, at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1940 to Oct 6 1940, and that I last saw h- alive on Oct 6 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hrs
Due to	
Due to	
Other conditions Or. Lobar Pneumonia (Include pregnancy within 3 months of death)	4 days

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice F. Klemans, Md
M. D. or other
Address 31 South St Annapolis Date signed 10/6/40

RECEIVED
NOV 5 1940
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-08

CERTIFICATE OF DEATH

10309

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Frederick

City or town Frederick Hgts

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Hammonds Ferry Rd or Fremwood

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Frederick Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Hammonds Ferry or Fremwood

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Minnie M. A. Guffner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6 (b) Name of husband or wife Emil Guffner

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1882

8. AGE: Years	Months	Days	If less than one day
58	3	19	hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name August Schmidt

13. Birthplace Germany

MOTHER 14. Maiden name Ernstine Gliepe

15. Birthplace Germany

16. Informant Mrs. Fred Schubert

Address Hammonds Ferry or Fremwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21, 1940 (month) (day) (year)

Cemetery or crematory Immanuel

Location Linden Lane

18. Funeral director Louis Hemann & Son

Address 32 S. Broadway

19. (Date rec'd by registrar) October 19 40 Caldwell Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1940, at 1120 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1940, to Oct 17 1940, and that I last saw her alive on Oct 17 1940

	DURATION
Immediate cause of death Internal Hemmorrhage	2 days
Due to Cancer of Stomach	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Raymond E. Glaum M. D. or other

Address 2108 Hollins Ferry Rd Date signed Oct 18/40

R. V. Glann

2708 S Hollins Ferry Ln

RECEIVED
OCT 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10310

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yrs. 8 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 602 Howard Street, Baltimore
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: WILLIAM H. GROOMES

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1921

8. AGE: Years	Months	Days	If less than one day
19	Unknown		..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ---

FATHER
12. Name: Howard Groomes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Goldie Brown
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/31/40 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto Md
18. Funeral director: Isaiah L Brown Son
Address: 108 W Montgomery St
19. 10/28/40 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27th 19 40, at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15th 19 38 to Oct. 27th 19 40 and that I last saw him alive on Oct. 27th 19 40

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury: Injured at work?

23. SIGNATURE: Wm H Groomes M.D., or other
Address: Crownsville, Maryland Date signed: 10/27/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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NOV 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10311

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (83a) Social Security No. 215-14-5269

County Anne Arundel Registration Dist. No. 27

Village or City Fort George G. Meade, Md. No. Station Hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME George W. Hall (Initial only, verified) If U. S. Veteran, specify WAR –

(a) Residence: No. Glenburnie, Md. St., – Ward. –
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Hall

6. DATE OF BIRTH (month, day, and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	–	–	–

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. –

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. –

10. Date deceased last worked at this occupation (month and year) – 11. Total time (years) spent in this occupation –

12. BIRTHPLACE (city or town) Severn, Md.
(State or country) Anne Arundel

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) "
(State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) "
(State or country)

17. INFORMANT James Spriggs
(Address) Cedar Hill, Brooklyn, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Cemetery Date October 11, 1940

19. UNDERTAKER Isiah L. Brown & Son
(Address) 108 W. Montgomery St. Baltimore, Md.

20. FILED Oct. 8, 1940, 19
D.P. CARD, Colonel MC, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 8 (Day), 1940 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from September 6, 1940, to October 8, 1940

I last saw h... im alive on October 8, 1940; death is said to have occurred on the date stated above, at 10:25A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importence were es follows:

	Date of onset
Ceberal Hemorrhage due to:	
Arterial Hypertension and	
Generalized Arteriosclerosis.	

Other **Contributory Causes** of importence:

Name of operation Date of

Whet test confirmed diagnosis? Was there an autopsy?

23. If death was due to externel ceuses (VIOLENCE) fill in elso the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, couoty and State)

Specify whether injury occurred In INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. M. Daly Contr. Surg. M. D.

(Address) J. M. DALY, Contract Surgeon, Fort George G. Meade, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10312

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Herald Harbor, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Herald Harbor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Edward Hall

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Adda M. Hall
10/20/1946
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Sept 18 1865

8. AGE: Years: 81 | Months: - | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Massillon, Ohio (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: Henry F. Hall
13. Birthplace: Marion Ohio

MOTHER
14. Maiden name: Eleanor White
15. Birthplace: Cincinnati Ohio

16. Informant: Adda M. Hall
Address: Herald Harbor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1940 (month) (day) (year)
Cemetery or crematory: Cross Roads
Location: Millersville, Md.

18. Funeral director: B. I. Hopkins
Address: Annapolis, Md.

19. 10/3 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2 1940, at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2 1940, to Oct. 1940
and that I last saw h. alive on Oct. 2 1940

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Generalized arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel Bowen M.D. M. D. or other
Address: Annapolis, Md Date signed: Oct. 2 1940

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NOV 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

(I)

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10313

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: A. A.

City or town: Aberdeen
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rural Near Annapolis. Md

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 11 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No: Aberdeen Near Annapolis Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Samuel H. Harris

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Malinda Harris

6(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): March 27 - 1866

8. AGE: Years: 74 Months: 6 Days: 10 If less than one day: hrs. min.

9. Birthplace: Balto Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Charles E Harris

Address: Annapolis. Md R.F.D.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Oct 9/40
(month) (day) (year)

Cemetery or crematory: Hope Chapel

Location: South River Md

18. Funeral director: B T Hopping

Address: Annapolis - Md.

19. 10 9 1940
(Date rec'd by registrar)

J. J. Murphy
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1940, at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1939 to October 7 1940, and that I last saw him alive on October 7 1940.

Immediate cause of death: Cardio-Renal Disease — DURATION: 2 mo.

Due to

Due to

Other conditions: Phlebitis — 17 mo.
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Lawrence W. Greene M.D.
M. D. or other

Address: Annapolis — Date signed: 10/8/40

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

10314

Reg. Dist. No. 22

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Anne Arundle

City or town: Odenton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Severn & Odenton Rds.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundle

City or town: Odenton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Severn & Odenton Rds.

(If rural, give LOCATION)

2.(a) If veteran, name war

*3. (a) FULL NAME: MARY ANN HOOD

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Hood

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 23, 1858

8. AGE: Years	Months	Days	If less than one day
81	9	15	..... hrs. ..... min.

9. Birthplace: A. A. Co., Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: William Lowman

13. Birthplace: A. A. Co., Maryland

MOTHER 14. Maiden name: Liza Ann Arnold

15. Birthplace: A. A. Co., Maryland

16. Informant: Mr. Lester Hood,

Address: Odenton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/40 (month) (day) (year)

Cemetery or crematory: Nichols Memorial

Location: Odenton, Maryland

18. Funeral director: Wm. J. Tickner & Sons,

Address: North & Pa. Avenues

19. Oct 11 1940 (Date rec'd by registrar) N. L. Jones D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8, 1940, at 5.55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1939, to Oct. 6 1940

and that I last saw h.. alive on Oct. 6 1940

Immediate cause of death	DURATION
Chronic Myocarditis	1 Month
Due to: Arterio-Sclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Claffy, M. D. M. D. or other

Address: Annapolis Md. Date signed 10/10/40

Dr. John M. Clapp,
Annapolis, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94P)

CERTIFICATE OF DEATH

10315

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Waterbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Millersville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Josepha Hoffa

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Hoffa
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 15 - 1874

8. AGE: Years: 66 | Months: 7 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: —

FATHER
12. Name: Waterbowski
13. Birthplace: Poland

MOTHER
14. Maiden name: Susan
15. Birthplace: Poland

16. Informant: (daughter) Veronica Bell
Address: Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26. 1940 (month) (day) (year)
Cemetery or crematory: Our Lady of the Fields
Location: Millersville Md

18. Funeral director: B L Hopkins
Address: Annapolis Md.

19. 10 26 1940 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1940 at 8.45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 - 8 am 1940, to 8.40 am Oct 23 1940
and that I last saw h. alive on Oct 23 - 1940

Immediate cause of death	DURATION
Cardiac Insufficiency	2 hrs
Angina Pectoris	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. H. McKenzie M. D. or other
Address: Millersville Date signed: Oct 23 40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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OCT 31 1940
BUREAU V. S.

10316

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A A

City or town Drury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Johnson

3. (b) Social Security Number 579-18-46021

4. Sex M

5. Color or race Col

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Ineze Johnson

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Feb. 25 1896

8. AGE: Years 44 Months 7 Days 13 If less than one day ___ hrs. ___ min.

9. Birthplace Drury, A. A. Co.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Alfred Johnson
13. Birthplace St Mary's

MOTHER
14. Maiden name Elizabeth Owens
15. Birthplace St Mary's

16. Informant James Johnson
Address Drury P. O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12 1940 (month) (day) (year)

Cemetery or crematory Moses Cem -

Location Drury

18. Funeral director J. B. Johnson
Address Annapolis

19. Oct 12th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1940, at 8 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3 1940, to Oct 8 1940, and that I last saw him alive on Oct. 8 1940.

Immediate cause of death bilateral bronchopneumonia.

~~Due to~~ Thrombo-phlebitis 1st. popliteal vessels

~~Due to~~ General paresis malnutrition

Other conditions dehydration

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Bornuch M.D. M. D. or other

Address Annapolis. Md Date signed 10/8/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1940
U. S.

10317

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A.

City or town: Severn (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Telegraph Rd.

Stay in hospital or inst. (yrs., or mos., or days): None

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Severn Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Telegraph Rd. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Herman Edward Infant of Herman and Lyda Kinder

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife: None

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Stilborn Oct 3, 1940

8. AGE: Years: 0 Months: Stilborn Days: If less than one day: hrs. 0 min.

9. Birthplace: Severn Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Herman Kinder

13. Birthplace: Md.

MOTHER

14. Maiden name: Lyda Hartman

15. Birthplace: Md.

16. Informant: Lyda Kinder

Address: Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 4, 1940 (month) (day) (year)

Cemetery or crematory: Marley Med. Ch yd.

Location: Anne Arundel Co.

18. Funeral director: Thomas W. Swigleton

Address: Glen Burnie, Md

19. Oct 4, 1940 (Date rec'd by registrar) McWe Alba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 1940, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Stillborn

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Raymond V Glaser M. D. or other

Address: 2208 Hollins Ferry Rd. Date signed: Oct 4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (11)

10318

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Arundel
City or town RURAL NEAR N. LINTHICUM
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or insf. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Arundel
City or town RURAL NR N. LINTHICUM Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 121 Nursery Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth (Ester) Lynch
3. (b) Social Security Number —

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Jerry Lynch
Nee Pullis
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Oct. 28, 1875
8. AGE: Years 62 Months Days If less than one day ____ hrs. ____ min.
9. Birthplace Baltimore ?
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name ~~Unknown~~ C. A. Rose
13. Birthplace " " Germany
MOTHER 14. Maiden name " ~~[illegible]~~
15. Birthplace " " Germany
16. Informant Jerry Lynch
Address 121 Nursery Rd
17. Burial Date thereof Oct 18-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park
Location Frederick Rd
18. Funeral director Joseph Kasinskas Inc
Address 602 Washington Blvd
19. 17 Oct 1940 Carl Wood Woodruff
(Date rec'd by registrar) Registrar

17 Oct 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 15 1940, at 8:00 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT 13 1938, to OCTOBER 15 1940, and that I last saw her alive on OCTOBER 14 1940.

Immediate cause of death	DURATION
DIABETES MELLITUS	3 YEARS
Due to	
Due to	
Other conditions ARTERIOSCLEROSIS	3 YEARS
CHRONIC ARTHRITIS	3 YEARS

(Include pregnancy within 8 months of death)
Major findings:
Of operations NONE
Of autopsy NONE

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Edward F. Milan M.D.
M. D. ~~or other~~
Address 682 WASHINGTON BLVD BALTIMORE MD Date signed 10-16-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13(a)

CERTIFICATE OF DEATH

Dr. West 10319

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A.
City or town Lothian
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Lothian Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles D. Magruder

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Florence Magruder
6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 1 1876

8. AGE: Years	Months	Days	If less than one day
64	6	1	hrs. min.

9. Birthplace A. A. Co - Lothian
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Bedford Magruder
13. Birthplace Charles Co.
MOTHER 14. Maiden name Margret Donell
15. Birthplace Charles Co.
16. Informant Florence Magruder
Address Lothian P.O. A.A.Co.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-5-40 (month) (day) (year)
Cemetery or crematory Mt. Hope
Location Lothian
18. Funeral director J B Johnson
Address Annapolis
19. Oct 4 1940 H. R. Clayton
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1940, at 1.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1st 1940, to Oct 2 1940, and that I last saw him alive on Oct 1st 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	
Chronic Nephritis	
Due to	
Senile Debility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J B Tash M. D. or other
Address Lothian Md Date signed 10/3/40

RECEIVED
NOV 6 1940
U. S. DEPT. OF AGR.

10320

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Deale Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Alfred Marshall
3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 22. 1903

8. AGE: Years	Months	Days	If less than one day
37	2	11	hrs. min.

9. Birthplace: Deale, A. A County, Md.
(Town, county, and state)
10. Usual occupation: oyster tonging and fishing
11. Industry or business: same
FATHER 12. Name: Dale Hamilton Marshall.
13. Birthplace: Deale. Md.
MOTHER 14. Maiden name: Annie E Dunnigan.
15. Birthplace: Fishers Station, A.A. County, Md
16. Informant: Mrs Fannie Hockett.
Address: R.F.D #1, Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 4 40 (month) (day) (year)
Cemetery or crematory: St James.
Location: T. Wells Landing
18. Funeral director: T. A. Hardesty & Son
Address: Edgewater, Md.
19. Oct 4 1940 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1940, at 10 40 A M
21. I CERTIFY [illegible] Post mortem examination 19—
[illegible] Oct. 2 1940
Immediate cause of death: Coronary occlusion — DURATION: Sudden
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings of operations: — — —
Date of op. —
Autopsy ~~results~~: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — — — Date of — — —
Where did injury occur? — — — — — —
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) — — — — —
Means of injury — — — — Injured at work? — — —

23. SIGNATURE: John M Cathey Deputy Medical examiner.
M. D. or other
Address: Annapolis Md. Date signed 10/2/40

Mary F.

Sharpes
2 PM
Friday
Chris
Moses

RECEIVED
NOV 5 1940
BUREAU V. S.

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

10321

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Homeland Park, Linthicomb Heights P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 months

Hospital, Institution, or street address where death occurred: Main Ave. in rear of home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Homeland Park, Linthicomb Heights P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Janice Mason

3.(b) Social Security Number

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: —

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 7, 1939

8. AGE: Years 1 | Months 17 5 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: Homeland Park, Linthicomb Heights, P.O.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Delbert Mason
13. Birthplace: Virginia (Delta ville)

MOTHER
14. Maiden name: Lilly Taylor
15. Birthplace: A. A. County, Maryland

16. Informant: Mrs. Lilly Taylor
Address: Linthicomb Heights P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-26-40 (month) (day) (year)

Cemetery or crematory: Friendship Cem.

Location: Severn, Md

18. Funeral director: J. F. McCully
Address: 130 E. Fort Ave

19. Oct 25 1940 (Date rec'd by registrar) Mrs DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 1940, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that attended deceased from~~ Post-mortem examination ~~and that I last saw he was alive on~~ Oct. 24 1940

Immediate cause of death: Drowning

Due to: Fall into spring hole pool.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/24/40

Where did injury occur? Homeland Park Linthicomb Heights A.A., Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): in rear of home

Means of injury: fell into pool Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis Md Date signed: 10/24/40

RECEIVED
OCT 26 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (306)

10322

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 month 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: --------

3.(a) FULL NAME

JAMES L. MOLOCK

3.(b) Social Security Number

214-07-8711

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE:

Years	Months	Days	If less than one day
27	Unknown		..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Worked in cannery

11. Industry or business: ------

FATHER
12. Name: Charles Molock
13. Birthplace: Maryland

MOTHER
14. Maiden name: Grace Jackson
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial
(Burial, cremation, or removal. Which?)

Date thereof: oct 17-40
(month) (day) (year)

Cemetery or crematory: Parkmeck no

Location: Parkmeck

18. Funeral director: Lewis H Baynerm

Address: 201 washtonist Cambridge

19. 10/11 40 (Date rec'd by registrar) 19 40 J J Murphy, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10th 19 40, at 8:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29th 19 40, to Oct. 10th 19 40 and that I last saw him alive on Oct. 10th 19 40

Immediate cause of death: GENERAL PARALYSIS OF THE INSANE

DURATION

Due to .....

Due to .....

Other conditions: Lues

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op. .....

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of .....

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---------

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 10/10/40

RECEIVED
NOV 5 1940
BUREAU V. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CB

10323

CERTIFICATE OF DEATH

Reg. Dist. No. ~~239~~

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Laurel Race Track
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maestrict of Columbia County:

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: L-St. near 7th N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War.

3. (a) FULL NAME Harry Norton

3. (b) Social Security Number

4. Sex: male

5. Color or race: negro

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Gertrude Norton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1895 ~~Washington D.C.~~

8. AGE: Years 45 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Henry Norton Sr
13. Birthplace: Unknown

MOTHER
14. Maiden name: Hannah Deceased
15. Birthplace: Unknown

16. Informant: Gertrude Morton

Address: 636 L. St N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-18-40 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington - Virginia

16. Funeral director: Robert G. McGuire

Address: 1820-9th St N.W.

19. October 16 1940 (Date rec'd by registrar) Cora E. Wacleter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1940, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem examination 19 and that I last saw him alive on Oct. 15 1940

Immediate cause of death: Pulmonary Hemorrhage

Due to: Chronic pulmonitis T.B.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: / / / / / / Date of op. / /

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: / / / Date of: / /

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John McClaffy Deputy medical examiner M. D. or other

Address: Annapolis Md Date signed: 10/15/40

RECEIVED
NOV 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10324

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a - a -

City or town: Annapolis 2nd

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 83 Washington St -

Stay in hospital or inst. (yrs., or mos., or days): - -

Stay in this community (yrs., or mos., or days): 37 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a - a -

City or town: Annapolis Ward No. 4

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 83 Washington St -

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -

3. (a) FULL NAME: Margret V. Parker

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem -	Col -	- Married

6 (b) Name of husband or wife: Wm E Parker

83 Washington St 6(c) If alive, give age 69. years

7. Birth date of deceased (mo., day, yr.): Jan - 1 1873

8. AGE:

Years	Months	Days	If less than one day
67	9 -	30	- hrs. - min.

9. Birthplace: Annapolis Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: at Home,

FATHER 12. Name: Samuel Fmt -

FATHER 13. Birthplace: Annapolis Md.

MOTHER 14. Maiden name: Eliza Jane Thomas

MOTHER 15. Birthplace: Annapolis a a Co Md.

16. Informant: Wm E. Parker

Address: 83 Washington St -

17. Bowerhill (Burial, cremation, or removal. Which?) Date thereof: 11. 2. 1940 (month) (day) (year)

Cemetery or crematory: Bowerhill Cmt -

Location: Annapolis Md.

18. Funeral director: E. H. B. Parker

Address: 47 Washington St -

19. 11 - 1 (Date rec'd by registrar) 19 40 J. D. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1940 at 7.55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 19 1940 to Oct 30 1940, and that I last saw h-- alive on Oct 29 1940.

Immediate cause of death: Heart failure — DURATION: Immediate

Due to: Enlarged heart — 2 Months

Due to: -

Other conditions: -

(Include pregnancy within 3 months of death)

Major findings:

01 operations: -

Ot autopsy: -

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -

Means of Injury: - Injured at work?

23. SIGNATURE: Ambrose Garcia M. D. or other

Address: Annapolis Md Date signed: 10-31-40

by Garcia

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

10325

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A. Co.

City or town Harwood

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Rural, Harwood Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Alice Randall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	married

6 (b) Name of husband or wife George A. Randall

6(c) If alive, give age 70? years

7. Birth date of deceased (mo., day, yr.) May 17, 1864

8. AGE:

Years	Months	Days	If less than one day
76	4		hrs. min.

9. Birthplace A. A. Co. Maryland (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Own home

FATHER 12. Name Wilson Turner

FATHER 13. Birthplace A. A. Co. Md

MOTHER 14. Maiden name Ellen (Doesn't know)

MOTHER 15. Birthplace Not Known

16. Informant George A. Randall

Address Harwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 1940 (month) (day) (year)

Cemetery or crematory Carroll Cemetery

Location Prince George Co. Md.

18. Funeral director E. H. B. Parker

Address 47 Washington Street

19. Oct 18 1940 (Date rec'd by registrar) J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1940, to Oct 16 1940, and that I last saw h[illegible] alive on Oct 8 1940.

Immediate cause of death	DURATION
Myocardial Chronic	
Nephritis Chronic	
Due to	
Due to	
Other conditions Arteriosclerosis	
Gen. Debility	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. B. West M. D. or other

Address Lothian Date signed 10/16/40

RECEIVED
NOV 5 1940
BUREAU V. S.

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

10326

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 608 Bay Ridge Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 608 Bay Ridge Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ROBERT F. REVELLE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Revelle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 19, 1877

8. AGE: Years	Months	Days	If less than one day
63	1	15	..... hrs. ..... min.

9. Birthplace: Sommerset Co. Maryland
(Town, county, and state)

10. Usual occupation: Painter (retired)

11. Industry or business

FATHER
12. Name: Samuel Revelle
13. Birthplace: Sommerset Co. Md.

MOTHER
14. Maiden name: Hester Ann Somers
15. Birthplace: Sommerset Co. Md.

16. Informant: Mabel H. Revelle
Address: Eastport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 6, 1940 (month) (day) (year)

Cemetery or crematory: Edwards Chapel, A. A. Co. Md.

Location

18. Funeral director: John M. Taylor
Address: Annapolis, Md.

19. Oct 5 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1940, at 3 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1940, to Oct 4 1940 and that I last saw him alive on Oct 4 1940

Immediate cause of death	DURATION
Acute Dilatation of Heart	Oct 1st
Acute Myocarditis	Oct 1st
Due to: Arterio Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Basil M. D. or other

Address: Annapolis Md Date signed: Oct 5 1940

EIVED
OCT 21 1940
AU V. S.

VS A15 (I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a CB

10327

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Laurel Race Track
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:–
(For newborn infants give residence of mother)

State: Kentucky County:

City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME John R. Riley

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: unknown

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: about 48 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: not known
(Town, county, and state)

10. Usual occupation: stable man

11. Industry or business: Racing

FATHER
12. Name: unknown
13. Birthplace

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Fred DeGray

Address: Laurel Race Track Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Nov 23 1940
(month) (day) (year)

Cemetery or crematory: Marley Meth. Ch. Yard

Location: Anne Arundel Co.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Nov. 23 1940
(Date rec'd by registrar)

M. S. DeAlba Dep
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1940 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination

~~and that I last saw~~ ~~alive~~ on ... 19

Immediate cause of death: Coronary Thrombosis — DURATION: sudden

Due to: Arterio-sclerosis — unknown

Other conditions: Dropped dead at spigot while drawing a pail of water.
(Include pregnancy within 6 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: John M. Claffy — Deputy medical examiner
M. D. or other

Address: Annapolis Md — Date signed: 11/22/40

RECEIVED
DEC 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-8)

CERTIFICATE OF DEATH

10328

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Sept. 30. 1940

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Centreville Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: none (If rural, give LOCATION)

2.(a) If veteran, name war: ?

3. (a) FULL NAME: Felix Robinson

3. (b) Social Security Number:

4. Sex: male

5. Color or race: black

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Theodoria Robinson

6.(c) If alive, give age: 39 ? years

7. Birth date of deceased (mo., day, yr.): ?1895

8. AGE: Years: 45 Months: ? Days: ? If less than one day: ... hrs. ? min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: farm laborer

11. Industry or business: none

FATHER

12. Name: Doram Robinson

13. Birthplace: Md.

MOTHER

14. Maiden name: Elizabeth ?

15. Birthplace: Md.

16. Informant: Hospital records

Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15-40 (month) (day) (year)

Cemetery or crematory: Grassmere

Location: Grassville

18. Funeral director: Annie W Eddins

Address: Centreville Md

19. 10-14 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 10 13 1940 at 10 30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30. 1940, to Oct. 12 1940 and that I last saw him alive on Oct. 12. 1940

Immediate cause of death: General Paralysis of the Insane — DURATION: unknown

Due to: Central Nervous System Lues

Due to:

Other conditions: none

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ////////// Date of

Where did injury occur? ////////// (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ////////

Means of injury: Injured at work?

23. SIGNATURE: Herbert P. Kirkwood M. D. or other

Address: Date signed

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1214)

10329

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil Cecil Co
City or town: Rural Near Perryman Park
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 4 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil Cecil
City or town: Rural Near Perryman Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World

3. (a) FULL NAME: Jacob F. Sarsable

3. (b) Social Security Number: 212-18-2179

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma Bahes
6(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): July 22 - 1875
8. AGE: Years: 65 Months: 3 Days: - If less than one day: hrs. min.
9. Birthplace: Harford Co. Md (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: In canning House
FATHER 12. Name: Michael Sarsable
13. Birthplace: Germany
MOTHER 14. Maiden name: Caroline Bechtold
15. Birthplace: Germany
16. Informant: Mrs. Henry A. Lorey
Address: Severna Park Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 1 - 1940 (month) (day) (year)
Cemetery or crematory: Smith Chapel
Location: Aberdeen Md. R.F.D. Harford Co
18. Funeral director: Henry Tarring Sons
Address: Aberdeen Md.
19. Oct 29 1940 (Date rec'd by registrar) Matilda R. Deale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29th 1940, at 4:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1940 to Oct 29 1940
and that I last saw him alive on Oct 29 1940

Immediate cause of death	DURATION
Heart failure	
Hypertensive Cardio Vascular Heart disease	
Due to	
Due to	
Other conditions: Cirrhosis of Liver	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel Rubin M. D. or other
Address: 203 Potapsco Ave Date signed:

RECEIVED
NOV 4 1940

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

10330

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Sheadyside
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: no
Stay in hospital or inst. (yrs., or mos., or days): no
Stay in this community (yrs., or mos., or days): 20 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Frances Harmon Sayers

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Robert Sayers.
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Dec. 10, 1858

8. AGE: Years: 82 Months: 9 Days: 23 If less than one day ____ hrs. ____ min.

9. Birthplace: ~~Mass.~~ New Hampshire
(Town, county, and state)
10. Usual occupation: Retired Government Employee
11. Industry or business

FATHER
12. Name: Henry Clay
13. Birthplace: New Hampshire

MOTHER
14. Maiden name: Martha Marsh
15. Birthplace: New Hampshire

16. Informant: Fred Grimm
Address: 1513 L St. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5, 1940 (month) (day) (year)
Cemetery or crematory: Washington D.C.
Location: Arlington Nat'l Cemetery

18. Funeral director: The S.H. Hines Co.
Address: 2901 - 14th St. N.W. Washington D.C.

19. Oct 3 1940 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1940, to Oct 3, 1940, and that I last saw h is alive on Oct 3, 1940.

Immediate cause of death: coronary Thrombosis

Due to: arteriosclerosis

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson M. D. or other
Address: Lothian, Md. Date signed: 10/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10331

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital

(If outside city or towu limits, write RURAL and give nearest towu)

How long in above place of death? since Febr. 17. 1937

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 years, 8 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 636 Haw Ste

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Maggie Scott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	Cl.	married

6.(b) Name of husband or wife: Curty Scott

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1897 ?

8. AGE: Years	Months	Days	If less than one day
about 43 ?			hrs. min.

9. Birthplace: unknown (Towu, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER 12. Name: John Kalso

13. Birthplace: Md.

MOTHER 14. Maiden name: Elisa Turner ?

15. Birthplace:

16. Informant: Res. of Crownsville State Hosp.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 24 1940 (mouth) (day) (year)

Cemetery or crematory: Mount Zion

Location: Baltimore Co. Maryland

18. Funeral director: Joseph A. Linsky

Address: 409 N Mount St Baltimore Md

19. 20 Oct 1940 (Date rec'd by registrar) Caldwell Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20. October 40 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febr. 17. 1937 to Oct. 20. 1940 and that I last saw h alive on Oct. 20. 1940

Immediate cause of death	DURATION
general paresis of the insane (paresis)	minimum since 3 9/4 years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (Stste)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert Snowden M. D. or other

Address: Crownsville State Hosp. Date signed: Oct. 20. 40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1940

10332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-G)

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Harwood
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Harwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME William Dennis Sharps

3. (b) Social Security Number none

4. Sex: M
5. Color or race: C
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Maggie E. Marshall
6(c) If alive, give age 36 years
7. Birth date of deceased (mo., day, yr.): June 17 1900

8. AGE: Years 40 | Months 3 | Days 15 | If less than one day ___ hrs. ___ min.

9. Birthplace: Lothian, A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Farm hand
11. Industry or business: Farm
FATHER
12. Name: Thomas Henry Sharps
13. Birthplace: Bristol
MOTHER
14. Maiden name: Louise Moreland
15. Birthplace: Bristol
16. Informant: Thomas H. Sharps
Address: Harwood
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 4 (day) 40 (year)
Cemetery or crematory: Moses Cemetery
Location: Drury, Md.
18. Funeral director: T. A. Hardisty & Son
Address: Galesville, Md.
19. Oct 4 1940 (Date rec'd by registrar) W. R. Clayton Dep Ind Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1940, at 5:35 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to Oct. 2 1940, and that I last saw him alive on Sept. 28 1940.

Immediate cause of death: Carcinoma of Pancreas — DURATION 15 Mos.
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Dt operations: Exploratory Lap — Carcinoma of Pancreas
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE F. B. West M. D. or other
Address Lothian Date signed 10/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
H. MORGENTHAU JR.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

10333

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 4 yrs. 4 mos. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1818 Woodyear Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: IDA SMITH

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE:

Years	Months	Days	If less than one day
40	Unknown		... hrs. ... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-23-1940 (month) (day) (year)

Cemetery or crematory: Arbutus Cemetery

Location: Balto Md

18. Funeral director: George T. A. Gibson

Address: 1735 Druid Hill ave

19. 10/21. 40 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20th 1940, at 8:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17th 1936, to Oct. 20th 1940 and that I last saw her alive on Oct. 20th 1940

Immediate cause of death: Myocarditis; Chronic. C.W.S.R. Duration: six months.

Due to

Due to

Other conditions: -----
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: Injured at work? ----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 10/20/40

RECEIVED
OCT 23 1940
BUREAU V. S.

10334

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83 ...)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 175 King George
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James W. Stallings

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Elizabeth Stallings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 3d 1876

8. AGE: Years 64 | Months 3 | Days 30 | If less than one day ..... hrs. ..... min.

9. Birthplace: A. A. Co Md
(Town, county, and state)

10. Usual occupation: Oyersterman

11. Industry or business

FATHER
12. Name: Wm Stallings
13. Birthplace: A. A. Co. Md

MOTHER
14. Maiden name: Nielsen
15. Birthplace: Nielsen

16. Informant: Howard Stallings

Address: Shady Side A. A. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4th 1940 (month) (day) (year)

Cemetery or crematory: Quaker Burial Grounds

Location: West River A. A. Co Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. Oct 3rd 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2 1940, at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination ~~and that I last saw him alive on~~ Oct. 2 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	sudden
Due to Arterio-sclerosis	2 years or more
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md Date signed: 10/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10335

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Elvaton, Md. Millersville P.O (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Elvaton - Millersville P.O (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Daniel. H. Stoll

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Single.

6.(b) Name of husband or wife: None

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 5, 1884.

8. AGE: Years 56 | Months 5 | Days 76 | If less than one day ... hrs. ... min.

9. Birthplace: A.A. Co. (Now Brooklyn) (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Fathers Farm.

FATHER
12. Name: Henry J Stoll
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Margaret Imold
15. Birthplace: Baltimore, Md.

16. Informant: Mr. John Stoll

Address: Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 2 - 1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Anne Arundel Co.

18. Funeral director: Thomas W. Sughton

Address: Glen Burnie, Md.

19. Nov. 2, 1940 (Date rec'd by registrar) McDeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1940, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 VISIT OCT. 24 19...

and that I last saw h. 1M alive on OCT. 24 19...

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	8 dys.
Due to HYPERTENSION	
Due to CHRONIC INTERSTITIAL NEPHRITIS	UNKNOWN
Other conditions ARTERIO. SCLEROSIS	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John J Alexander, M. D. or other

Address: Glen Burnie Md Date signed: Oct. 31. 40

RECEIVED
NOV 18 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a) CD 10336

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: U.S.NAVAL HOSPITAL, Annapolis, Md.

Stay in hospital or inst. (yrs., or mos., or days): Four(4) Months

Stay in this community (yrs., or mos., or days): Six (6) Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: Philadelphia Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 6362 Tulip Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Norman George SYKES,

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-11-06

8. AGE: Years	Months	Days	If less than one day
m 34	6	17	hrs. min.

9. Birthplace: Philadelphia Pennsylvania
(Town, county, and state)

10. Usual occupation: Machinist Mate, U.S.Navy

11. Industry or business: U. S. Navy

FATHER
12. Name: Joseph SYKES
13. Birthplace: Philadelphia, Penna.

MOTHER
14. Maiden name: Charlotte LAMBERT
15. Birthplace: Atlantic City, New Jersey

16. Informant: C. C. THOMAS, Captain, (MC), U.S.N.
Address: U.S.Naval Hospital, Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 31-40 (month) (day) (year)

Cemetery or crematory: BODY SHIPPED TO UNDERTAKER

Location: WARREN E. TITUS, 6948 Torresdale, Ave. (Phila.Pa)

16. Funeral director: R. L. HOPPING,

Address: 170-172 West St., Annapolis, Md.

19. 10 31 19 40 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION 5:08 P.M.

20. DATE OF DEATH: 10-28-40 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-13-1940, to 10-28-1940, and that I last saw him alive on 10-28-40 19

Immediate cause of death	DURATION
Shock (Surgical)	3 Hrs.
Due to Operation for repair of Gastro-Jejuno-Colic Fistula	4 Mos.
Due to Gastro-Enterostomy, previously done for a Gastric Ulcer	3 Yrs.
	3 Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operation: Gastro-Jejuno-Colic Fistula at site of previous Gastro-Enterostomy.
Of autopsy: Operative findings confirmed.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. J. Cerny
A. J. CERNY, Lieut., (MC), U.S.Navy.
M. D. or other

Address: U.S.N.HOSPITAL, Annapolis, Maryland. Date signed: 10-29-40

RECEIVED
NOV 5 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84E)

CERTIFICATE OF DEATH

10337

Reg. Diat. No. 1

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: Eva Tomes

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: ~~Alex~~ George Tomes

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1914

8. AGE: Years: 26 | Months: Unknown | Days: | If less than one day: ....hrs. ....min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER — 12. Name: Perry (Unknown)

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1940 (month) (day) (year)

Cemetery or crematory:

Location: North Carolina

18. Funeral director: Mrs. George A. Holland

Address: 1631 Druid Hill Ave.

19. 10 24 40 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23rd 19 40, at 4:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16th 19 40, to Oct. 23rd 19 40

and that I last saw her alive on Oct. 23rd 19 40

Immediate cause of death	DURATION
Dementia Praecox	
Due to: Exhaustion with acute heart failure	
Due to:	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.:

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of:

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? ------

23. SIGNATURE: Herd J. Tomlinson M. D. or other

Address: Crownsville, Md. Date signed: 10/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10338

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 yrs. 3 mos. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3. (a) FULL NAME: MILTON TUBMAN

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE: Years	Months	Days	If less than one day
28	Unknown		hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: -----

FATHER
12. Name: Jimmy Tubman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alla (Unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 1, 1940 (month) (day) (year)
Cemetery or crematory: Cordtown
Location: Cordtown, Maryland

18. Funeral director: Harry A. Vodery
Address: 229 High Street, Cambridge, Md.

19. 11 3d 1940 (Date rec'd by registrar) J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29th 1940 at 5:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26th 1937 to Oct. 29th 1940 and that I last saw h... im alive on Oct. 29th 1940

Immediate cause of death	DURATION
Pulmonary tuberculosis	7 mos
Due to	
Due to	
Other conditions -----	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury: Injured at work? ----

23. SIGNATURE: Alex P. Harrison M.D. M. D. or other
Address: Crownsville, Md. Date signed 10/29/40

RECEIVED
NOV 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (185)

CERTIFICATE OF DEATH

10339

Reg. Dist. No. 27

1. PLACE OF DEATH

County: Anne Arundel

City or town: Jacobsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Mountain Road Jacobsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. at Hess's Store

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Henry John Walton Jr

3.(b) Social Security Number None.

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 6, 1920

8. AGE: Years: 20 | Months: 3 | Days: 29 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Irvington Lancaster Co. Va.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Amusement

MOTHER FATHER

12. Name: John Henry Walton Jr.

13. Birthplace: Virginia

MOTHER

14. Maiden name: Correal Lee Ashburn

15. Birthplace: Virginia

16. Informant: W. C. Haslip

Address: Jacobsville, Pasadena P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 17, 1940 (month) (day) (year)

Cemetery or crematory: Magothy Church yard

Location: Jacobsville A.A. Co. Md

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Oct. 15 1940 L. a. Breed

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1940, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~Mar 1/1/1940 to 1940~~ from Post Mortem examination 1940

~~Attended the deceased from~~ ~~Mar 1/1/1940 to~~ Oct. 15 1940

Immediate cause of death	DURATION
Hemorrhage	
Due to: Severing right femoral artery with butcher knife	
Other conditions: While boning a piece of beef	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 10/15/40

Where did injury occur? Jacobsville (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): in general store

Means of injury: long butcher knife Injured at work? yes.

23. SIGNATURE: John R. Claffy Deputy medical examiner

M. D. or other

Address: Annapolis Date signed: 10/15/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10340

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 81 Winters Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Washington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: Mary Washington
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years	Months	Days	If less than one day
71	unknown		hrs. min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Butler
11. Industry or business:

FATHER
12. Name: Walter Washington
13. Birthplace: Virginia

MOTHER
14. Maiden name: Fanny Reed
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1940 (month) (day) (year)
Cemetery or crematory: Arbutus Park
Location: Maryland

18. Funeral director: Mrs. Samuel T. Hemsley
Address: 578 W. Biddle St., Baltimore, Md.

19. Oct 26 40
(Date rec'd by registrar)
E. F. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25, 1940 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16, 1940, to October 25, 1940 and that I last saw him alive on October 25, 1940

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert V. Armstead M. D. or other
Address: Crownsville, Maryland Date signed: 10/26/40

RECEIVED
NOV 4 1940
BUREAU U. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10341

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (46-E)

County Anne Arundel Registration Dist. No. 27

Village or City Fort George G. Meade, Md. No. Station Hospital St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. - mos. - ds. How long in U.S. if of foreign birth? - yrs. - mos. - ds.

2. FULL NAME Jessie Mae Wells If U. S. Veteran, specify WAR -

(a) Residence: No. Fort George G. Meade, Md. St., Ward. -

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles R. Wells

6. DATE OF BIRTH (month, day, and year): November 28, 1865

7. AGE Years	Months	Days	If LESS than 1 day, - hrs. or - min.
74	10	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: -

10. Date deceased last worked at this occupation (month and year): -

11. Total time (years) spent in this occupation: -

12. BIRTHPLACE (city or town) (State or country): Brooklyn, New York

FATHER

13. NAME: Harvey Holly

14. BIRTHPLACE (city or town) (State or country): Unknown

MOTHER

15. MAIDEN NAME: Lavina Reynolds

16. BIRTHPLACE (city or town) (State or country): Brooklyn, New York

17. INFORMANT: Mrs. F. Dumont

(Address) Fort George G. Meade, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Ft Meade, Md. Oata Oct. 3, 1940

19. UNDERTAKER: Joseph Gawlers Sons

(Address) 756 Pennsylvania Ave. Wash, D.C.

20. FILED Oct 2 1940

D.P. CARD, Colonel, MC Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

October (Month) 2 (Day), 1940 (Yaar)

22. I HEREBY CERTIFY, That I attendad deceased from October 2, 1940, to October 2, 1940

I last saw her aliva on October 2, 1940; death is said to have occurred on the date stated above, at 4:05P m.

Tha PRINCIPAL CAUSE OF DEATH and ralated causes of importanca were as follows:

	Oate of onset
Carcinoma of transverse colon	Unknown

Other Contributory Causes of importanca: -

Name of operation - Oate of -

What test confirmed diagnosis? - Was there an autopsy? Yes

23. If death was dua to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? - Oate of injury - , 19 -

Where did injury occur? -

(Specify city or town, county and State)

Specify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE. -

Manner of injury

Nature of injury -

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Milo M. Kirk M.D.

MILO M. KIRK, 1st Lt Med Res. M. D.

(Address) Fort George G. Meade, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

10342

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3 yrs. 1 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (a) FULL NAME
WESLEY WILLIAMS

3. (b) Social Security Number
----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1877 (?)

8. AGE:

Years	Months	Days	If less than one day
63?	Unknown		..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER
12. Name: Alexander W. Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lois Williams
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 10/30-40 (month) (day) (year)

Cemetery or crematory: Crownsville

Location: "

18. Funeral director: Supt.

Address: /

19. 10/30 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26th 1940, at 7:35P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20th 1937, to Oct. 26th 1940 and that I last saw him alive on Oct. 26th 1940

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: -------

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 10/26/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 5 1940
BUREAU V. S.

VS A15 (T) (1) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124C)

10343

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 yrs. 8 mos. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: --------

3. (a) FULL NAME: CLARENCE WORMACK

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: --------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1903

8. AGE: Years: 37 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Oscar Wormack
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Minerva Senaca
15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/28-40 (month) (day) (year)

Cemetery or crematory: Crownsville

Location: do.

18. Funeral director: Supt.

Address:

19. 10/28 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22nd 1940, at 5P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17th 1937, to Oct. 22nd 1940 and that I last saw him alive on Oct. 22nd 1940

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	
Due to	
Due to	
Other conditions: Fatty dengeration of the liver Pyelonephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: ------ As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: -------- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 10/22/40

RECEIVED
NOV 5 1940
BUREAU V. S.